MEDICAID MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN FOR TITLE XIX

VOLUME VII MEDICAID THIRD PARTY LIABILITY DETERMINATION AND BENEFIT RECOVERY SUBSYSTEM

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

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FORWARD

This document is the Medicaid Third Party Liability Determination and Benefit Recovery (MTPLD&BR) Subsystem, Volume VII of the Medicaid Management Information System (MMIS) General Systems Design (GSD). This volume describes the functions which are needed to develop an automated system for third party liability as specified by section 1902(a)(25) of the Social Security Act and sections 2161 and 2182 of the Omnibus Reconciliation Act of 1981, and further defined in 42 CFR Part 433, subpart D, Third Party Liability.

The overall objective of Volume VII of the MMIS GSD is to improve the administration of title XIX by enhancing the capabilities of a State agency in defining whether or not a viable third party exists or potentially exists, through the use of automation. In order to accomplish this objective, emphasis has been placed on developing a general system design which will provide direction for use in data collection, distribution of data needed to support the integrity of third party information, and operational processing and management reports to achieve greater effectiveness in the administration of title XIX claims.

The functions and objectives of the general design represent criteria on which States are measured for conformance, in order to receive the increased Federal financial matching for claims processing and information retrieval systems as provided in section 235 of Public Law 92-603 (this includes a demonstratable conceptual equivalent system that may be technically different and still satisfies the functions and objectives of the MMIS-GSD).

The general design can be applied to any State or jurisdiction regardless of size or magnitude of the title XIX program in effect.

The Division of Systems Planning and Development, Office of Methods and Systems, Bureau of Program Operations, Health Care Financing Administration is responsible for development and maintenance of the MMIS GSD. Continuing periodic updates will be provided to meet program and MMIS functions.

Acknowledgement

The Health Care Financing Administration (HCFA), Bureau of Program Operations (BPO), Office of Methods and Systems (OMS) would like to express its utmost appreciation for the contribution of time and effort provided them by Federal and State persons in the development of the Medicaid Third Party Liability Determination and Benefit Recovery (MTPLD&BR) General Systems Design (GSD).

Appreciation is greatly expressed to the many individuals and organizations who directly and indirectly made Volume VII of the Medicaid Management Information System (MMIS) General Systems Design (GSD) possible.

Specifically, we would like to recognize the Systems Technical Advisory Group (STAG), G. Elmendorf, Co-chairperson; Third Party Technical Advisory Group (TP-TAG) consisting of F. Walpole, Co-chairperson, Oklahoma; G. Duffy, Michigan; B. Wahtera, Minnesota; K. Buzzard, New York, and B. Huffines, Tennessee. The HCFA central office, HCFA regional and State Medicaid persons who so graciously participated; R. Nakamoto, Director, Division of Systems Planning and Development (DSPD); N. Berry, Chief, Systems Development Branch (SDB); the third party project teams of: R. G. Young, Systems Analyst, Development Project Manager; R. B. Carter, Systems Analyst, Development Project Officer; C. Smith, A. Czerski, and F. Bender of HCFA central office; J. Hansen, California, D. Best, North Carolina; Medicaid personnel in the States of Florida, Georgia, Kansas, Michigan, Minnesota, Ohio, Pennsylvania, Texas, and West Virginia for allowing us time to review their Medicaid Third Party systems.

There are others too numerous to name, who also gave their assistance in completing this project; to those unnamed, especially the secretaries, we greatly acknowledge their contributions and efforts.

MEDICAID

MANAGEMENT INFORMATION SYSTEM

GENERAL SYSTEMS DESIGN

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Introduction

A. General

The General Systems Design of the model Medicaid Management Information System is a product of the Bureau of Program Operations, Health Care Financing Administration, Department of Health and Human Services.

The Medicaid Third Party Liability Determination and Benefit Recovery Subsystem is comprised of a subsystem introduction, summary, design elements, management narratives, third party resource data base, and three individual modules within the subsystem, a glossary of terms and data element definitions.

B. Documentation Organization

The Medicaid Third Party Liability Determination and Benefit Recovery Subsystem documentation is a departure from the Medicaid Management Information System documentation and is presented within its respective section, Volume VII as follows:

1. Subsystem introduction and summary; where the purpose and objectives of the subsystem are itemized and a general description is provided.

2. Design elements; where all assumptions and constraints imposed are listed, where considerations affecting the design of the subsystem are discussed, and where controls and audit trails are established to insure subsystem integrity are listed.

3. Management narratives, a detail description is furnished of the third party resource data base and how each module functions within the subsystem.

4. Third party resource data base, its purpose and concepts are defined. Source data, descriptions and information flow are presented and discussed in detail.

5. Subsystem modules; cost avoidance, benefit recovery and reporting are described. Input/output and information flows are discussed and presented for each module.

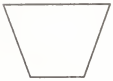
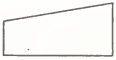
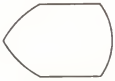
6. A glossary which indicates the specialized terms used in the design documentation.

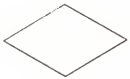
7. Specialized third party data elements have been defined and assigned a data element code. A recommended coding structure is provided for the data elements where appropriate. The data elements contained in Volume V of the Medicaid Management Information System are required for use in this subsystem and are referenced.

C. Flowchart Symbol Explanation

In certain portions of the General Systems Design documentation flowcharts are used to graphically describe the processing flow. An explanation of the symbols employed is furnished on the following pages.

Flowchart Symbols

Symbol	Explanation
	Terminal point - indicates exit from a module to another module or subsystem; indicates entry to a module from another module or subsystem.
	Document - computer printed output; manually created reports; source documents.
	Manual process step - a step in which no equipment, other than normal clerical devices, is used.
	Keying - a process step involving the generation of machine readable records using a key driven device.
	Manual input - information input by on-line keyboards.
	Display - information display by on-line video devices.
	Computer processing step processing which takes place in the computer.

Symbol	Explanation
	Off-Line file - a file of nonmachine readable data such as documents.
	Decision - a processing step (manual or computer) in which a decision is made and one of several alternatives selected.
	Off-Line equipment processing - a processing step which utilizes off-line equipment (e.g., sorter, microfilm machine).
	Input/Output function in card medium.
	On-Line file - a file composed of machine readable data (e.g., drums, tape, disk).
	On-Page connector - indicates entry to a process from a point on the same page; indicates exit to a process on the same page.
	Off-Page connector - indicates entry to a process from another page; indicates exit to a point on another page.

D. Documentation Nomenclature

1. Design Element Identification

As a part of the General Design documentation for individual subsystems, specifications for inputs, outputs, and data files are provided. To provide a means of unique identification for these design elements, the following reference scheme is used:

XX-Y-ZZ

where XX identifies the source subsystem for the design element per the abbreviations:

- RS Recipient Subsystem
- PS Provider Subsystem
- CP Claims Processing Subsystem
- RF Reference File Subsystem
- SU Surveillance and Utilization Review Subsystem
- MR Management and Administrative Reporting Subsystem
- EP Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Subsystem
- TP Third Party Liability Determination and Benefit Recovery Subsystem

where Y identifies the design element per the following code:

- O Output
- I Input
- F File

where ZZ is a unique two digit number identifying the particular design element

2. Data Element Numbering

Each subsystem serves as a point of entry for various data elements that are collected, processed, and displayed on one or more outputs from the Model System. The following ranges of number are allocated by subsystem for assignment to data elements that originate in that subsystem.

100-199	Recipient Subsystem
200-299	Provider Subsystem
300-499	Claims Processing Subsystem
500-599	Reference File Subsystem
600-699	Management and Administrative Reporting Subsystem
700-799	Surveillance and Utilization Review Subsystem
800-899	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Subsystem
1100-1199	Third Party Liability Determination and Benefit Recovery Subsystem

3. Flowchart Connectors

As a part of the documentation of each subsystem, module flowcharts are furnished to describe the processing flow. In some instances, more than one flowchart page is required for a module. This situation results in the need for processing connectors as follows:

where X is the number of a specific flowchart page.

If the flowchart indicates an exit connect then X is the page to which exit is made.

If the flowchart indicates an entry connect then X is the page upon which entry is made.

Y is the unique number designating a particular exit or entry on the page.

For example:

From page 4 exit connector

To page 6 entry connector

MEDICAID

MANAGEMENT INFORMATION SYSTEM

SECTION X

MEDICAID THIRD PARTY LIABILITY DETERMINATION AND BENEFIT RECOVERY SUBSYSTEM

SECTION X

MEDICAID THIRD PARTY LIABILITY DETERMINATION
AND BENEFIT RECOVERY SUBSYTEM

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SECTION X MEDICAID THIRD PARTY LIABILITY DETERMINATION AND BENEFIT RECOVERY SUBSYSTEM (MTPLD&BR)

A. Third Party Liability Subsystem Introduction

The third party liability determinations for the title XIX Medicaid program is mandated by section 1902(a)(25) of the Social Security Act and sections 2161 and 2182 of the Omnibus Reconciliation Act of 1981. The acts provide that States must: (1) take reasonable measures to determine the legal liability of third parties; (2) treat the verified third party liability as a resource of the Medicaid applicant or recipient if payment from such source is determined to be currently available; and (3) effect procedures for securing reimbursement from third parties if payment from such sources is determined appropriate after medical services have been paid from title XIX funds. The design covers those functions that will assure that title XIX of the Medicaid program is the payor of last resort.

The Third Party (TP) subsystem is designed in the context of defining whether or not a viable TP exists or potentially exists. These objectives will be accomplished through the identification and verification of any resource indicating the possibility or existence of a responsible source providing no third party indicator is present.

Concern over development and delivery of a model subsystem defining MTPLD&BR has been acknowledged by the Federal Government as necessary to assist the States in meeting criteria for Federal participation. In defining this subsystem and establishing provisions for providing technical assistance and financial support, States will be able to function in a more cost effective mode. Also, each State will be able to identify and establish a more effective administrative policy in reducing program cost.

B. Third Party Liability Subsystem Summary

1. Objectives

The General Systems Design (GSD) for the MTPLD&BR (Medicaid subsystem) has been developed to address the single State agency managerial needs and the operational aspects. After extensive research and analysis of the existing functional and system requirements, the decision was made to develop a new subsystem for GSD to give additional direction to a TP program.

The MTPLD&BR subsystem will provide a model for the States in the development of a system established under the Medicaid Management Information System (MMIS). The subsystem will also provide direction for use in data collection, reporting, and distribution of data needed to support the TP data integrity, operational processing, and management reports.

The sources most instrumental in determining possible TP existence in claims processing lie within system edits. Through the use of edits, determinations can be made on whether to cost-avoid (divert) or do postpayment recovery (benefit recovery) if TP is determined to exist.

There are three methods for administering the claims payment where third party involvement exists. These options are:

Method 1: A State agency returns a claim to the provider unpaid because of the known existence of third party liability; and/or a provider may bill a third party directly, and bill the State Medicaid agency only for amounts not covered by the third party. This method is termed cost avoidance.

Method 2: A provider may bill the State Medicaid agency and the agency subsequently seeks reimbursement from the third party. This method is termed postpayment recovery.

Method 3: A State may use a combination of both the cost avoidance and post-payment recovery methods. This method of administering claims reduces the manual intervention used to determine the liability of others and could potentially reduce the involvement of benefit recovery operations.

Regardless of the method for administering the claims payment process selected by a State, the resources currently available to the recipient must be determined. Through the use of edits, based upon the resource information and related claims data, determinations can be made on the existence of potential third party liability and/or claims diversion or postpayment recovery.

2. General Description

The subsystem as designed in this document will establish a firm foundation to build a MTPLD&BR subsystem. The area of major concern in designing this system is the collection and gathering of data elements regarding recipient, health insurance, and other resource information. The system emphasizes accounting practices and utilization of data to cost avoid and to effectuate direct recovery from identified resources. The reliability and accessability of this information is of utmost importance in establishing effective cost avoidance criteria and benefit recovery techniques.

The primary benefit from using the automated account receivable and recipient file information will be a reduction in manual processing. The automated system will provide the ability to identify the health insurance carrier. Any additional staff time saved because of the reduction in manual processing could be channeled toward the investigation of Medicaid claims identified as having a potential for third party involvement (e.g., other insurance coverage, Tort, and Estate).

In summary, automation will improve the responsiveness of the Medicaid Third Party Liability determination and benefit recovery process.

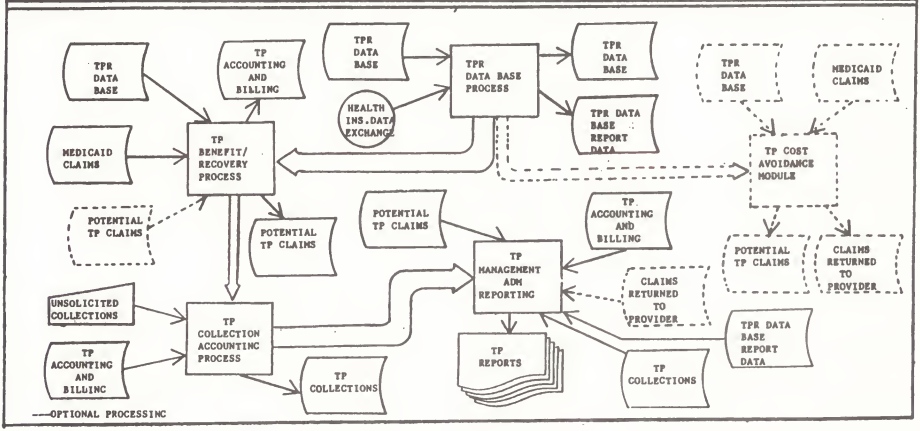
3. Information Flowchart

See Information Flowchart, next page.

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
CENERAL DESICN DOCUMENTATION

PROCESSING FLOW

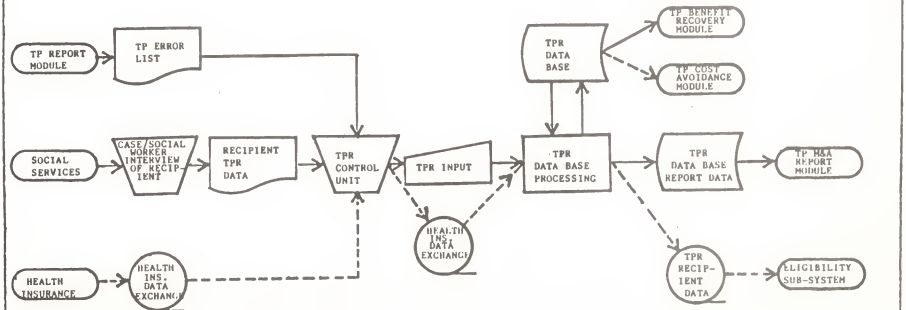
MEDICAID THIRD PARTY LIABILITY DETERMINATION & BENEFIT RECOVERY SUBSYSTEM - SYSTEM OVERVIEW



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

PROCESSING FLOW CHART

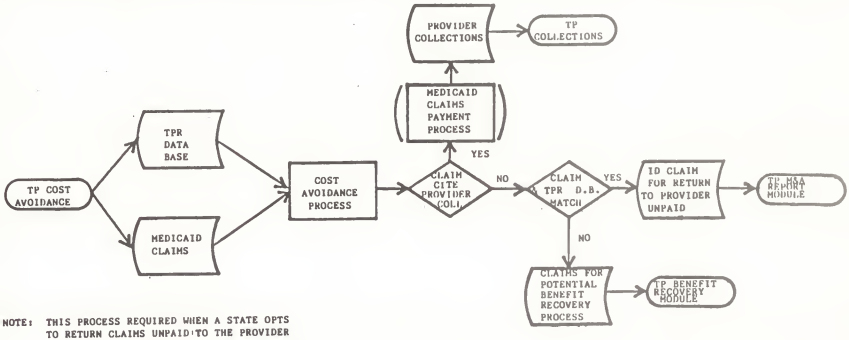
MEDICAID THIRD PARTY LIABILITY DETERMINATION & BENEFIT RECOVERY SUBSYSTEM – THIRD PARTY (TP) DATA BASE PROCESS



MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

PROCESSING FLOW CHART

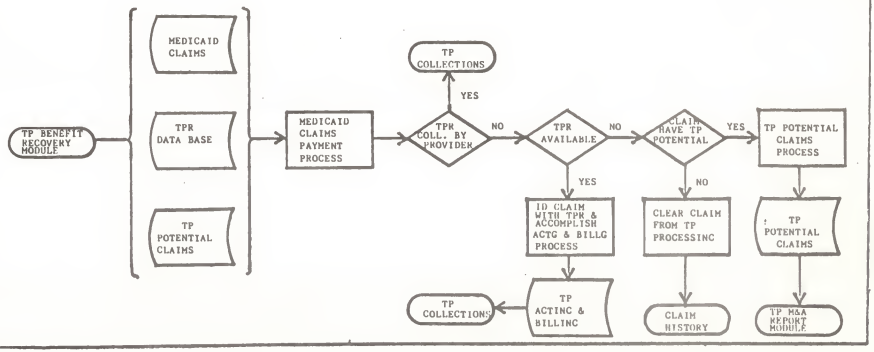
MEDICAID THIRD PARTY LIABILITY DETERMINATION & BENEFIT RECOVERY SUBSYSTEM - OPTIONAL THIRD PARTY COST AVOIDANCE MODULE



NOTE: THIS PROCESS REQUIRED WHEN A STATE OPTS TO RETURN CLAIMS UNPAID TO THE PROVIDER

MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM GENERAL DESIGN DOCUMENTATION	PROCESSING FLOW CHART

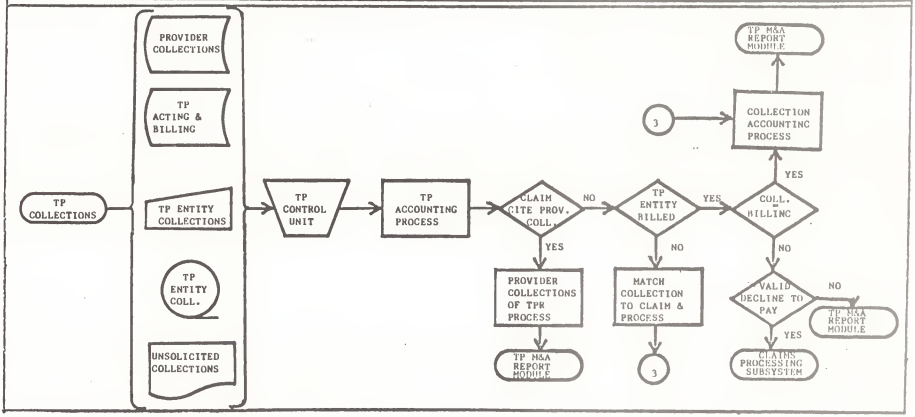
MEDICAID THIRD PARTY LIABILITY DETERMINATION & BENEFIT RECOVERY SUBSYSTEM – THIRD PARTY BENEFIT RECOVERY MODULE

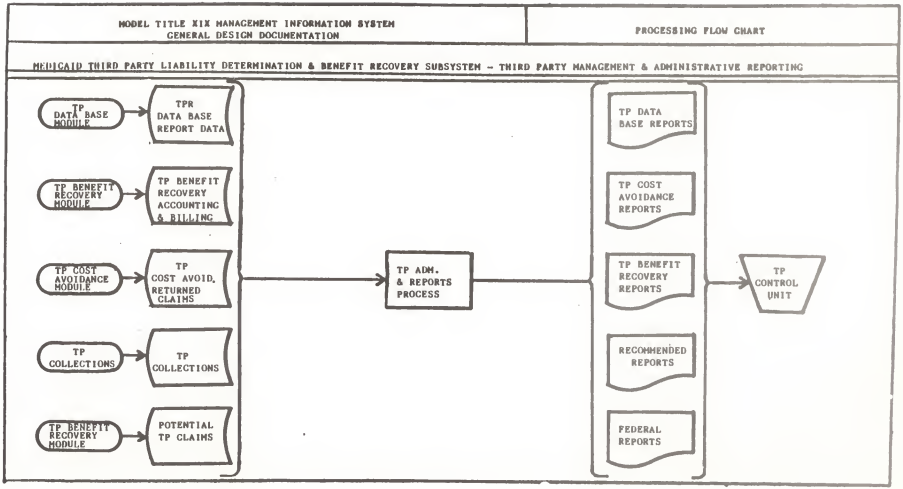


MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

PROCESSING FLOW CHART

MEDICAID THIRD PARTY LIABILITY DETERMINATION & BENEFIT RECOVERY SUBSYSTEM - THIRD PARTY COLLECTION MODULE




MODEL TITLE XIX MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION
PROCESSING FLOW CHART
MEDICAID THIRD PARTY LIABILITY DETERMINATION & BENEFIT RECOVERY SUBSYSTEM – THIRD PARTY MANAGEMENT & ADMINISTRATIVE REPORTING
TP DATA BASE MODULE
TPR DATA BASE REPORT DATA
TP BENEFIT RECOVERY MODULE
TP BENEFIT RECOVERY ACCOUNTING & BILLING
TP COST AVOIDANCE MODULE
TP COST AVOID. RETURNED CLAIMS
TP COLLECTIONS
TP COLLECTIONS
TP BENEFIT RECOVERY MODULE
POTENTIAL TP CLAIMS
TP ADM. & REPORTS PROCESS
TP DATA BASE REPORTS
TP COST AVOIDANCE REPORTS
TP BENEFIT RECOVERY REPORTS
RECOMMENDED REPORTS
FEDERAL REPORTS
TP CONTROL UNIT

C. Design Elements

The MTPLD&BR subsystem of the MMIS considered the following constraints in the development and support of the Medicaid third party activities:

1. Constraints and Assumptions

a. The design must be compatible with the MMIS-GSD. The MMIS-GSD is the basic foundation upon which Medicaid claims processing activities are based. Inclusions of additional resources as it applies to the recipient are required to support third party determination functions.

b. The design must consider TP from the following points:

(1) The addition of TP information which will not impact the State's current ability to pay Medicaid claims.

(2) The data base to maintain TP resource information which can be used in either cost avoidance or benefit recovery processes, or a combination of both. This will allow a State to design its MTPLD&BR to improve its current operations without changing its current claims payment flow.

(3) Provide options identifying the basic requirements necessary to allow a State to implement a primary benefit recovery process or a cost avoidance process, or a combination of the cost avoidance and benefit recovery processes. The option is dependent on the method for determining TP claims selected by the State.

(4) Provide for the basic requirements of TP resource information and for other agencies which determine eligibility from an integrated data base for programs of the categorically and medically needy only individuals.

c. The design will provide a single set of standards for initial certification which must be met by a State's MMIS system to qualify for increased Federal Financial Participation (FFP).

d. The design is to be supportive of Federal regulatory requirements which direct and maintain that the Medicaid program be established as payor of last resort.

e. The design is flexible and supports Federal reporting requirements and will not prevent necessary modifications supporting operational management of the TP unit and/or new requirements as they are levied.

f. The design assumes that:

(1) State has in effect supportive legal basis with which to cost avoid and recover benefits.

(2) State will pursue Medicaid dollars from other resources within a specified time frame as dictated by regulatory requirements.

(3) Systems in place support TP determinations that can be modified and used in conjunction with currently available hardware and software packages.

(4) Personnel or the existence of a plan is in place to support the TP functions.

2. Design Considerations

The following items were given consideration during the design of the TP data base:

- States that have an operational MMIS have the capability to effectuate proper cost avoidance activities in conjunction with benefit recovery (postpayment recovery) activities.
- No attempt will be made to change any definition or data elements cited in the current MMIS-GSD.
- Third party resource information currently in existence is for the most part in a nonautomated form and is maintained as part of eligibility case files.
- Case/social workers will be the primary source used in obtaining third party health insurance information from the Medicaid eligible individual/family.
- Casualty/injury insurance information for the most part will have to be identified and researched. Normally, this information will be identified from an indicator cited on the invoice (claim) by the provider of the health care service, or the traumatic diagnosis codes and procedure related codes identified as having potential for recovery.
- Source data for the TPR data base must interface with the eligibility, claims processing, provider, and management, administrative reporting subsystems of the MMIS-GSD.

3. Control and Audit Trails

The processing of information within the MTPLD&BR subsystem will require the following controls and/or audit trails be established.

a. System Controls

(1) Establish a Third Party Resource (TPR) data base.

(2) Establish interface between eligibility subsystem and TPR data base.

(3) Establish an interface with claims processing subsystems.

(4) Establish accountability for third party billing.

(5) Establish a reconciliation process between TP accounting and third party collections.

(6) Record third party collections as cited on provider claims submitted to single State agency.

(7) Edit all appropriate data items for completeness prior to update of the third party resource data base.

(8) Provide an audit trail of changes made to the third party record.

(9) All data bases will be labeled and checked by the computer to insure correct data base processing.

(10) Control totals and processing dates will be maintained for the data base to insure accurate accounting of all records processed.

b. Program Performance Controls

Program Performance Controls are part of the mandatory reporting requirements as described later in paragraph H 2.

D. **Management Narratives**

The scope of this system is to provide information to States with regard to Federal systems requirements in support of TP determinations. The Medicaid Third Party Liability Determination and Benefit Recovery (MTPLD&BR) subsystem of the Medicaid Management Information System (MMIS) describes the functions and standards a

State must meet to qualify for the increased Federal Financial Participation (FFP) as required by 42 CFR 433, subpart C and the State Medicaid Manual, Part 11. The functions of the MTPLD&BR subsystem are:

- To identify and control the known Medicaid recipient TP information; e.g., veterans' benefits, workers' compensation, court orders, casualty, CHAMPUS, and private health insurance.
- To identify potential liable conditions where third party involvement has a high degree of occurrences indicated by accident related claims showing traumatic diagnosis.
- Provide for expanded interfaces between MMIS subsystems and other systems which support State and Federal laws, regulations, and policy.
- Provide expanded MMIS reporting capability and its' utilization.

1. Third Party Resource Data Base

   The collection of information on third party resources and/or potential resources which have been determined to be available to client.

2. Third Party Cost Avoidance Module

   a. Provide third party information for use in the eligibility subsystem of the MMIS for utilization in the preparation of the Medicaid identification medium.

   b. Utilization of Resource Data editing for cost avoidance determination.

   c. Provide for accountability of funds for applied TP resources.

   d. Provide the potential to reduce the initial Medicaid dollar outlay through the institution of prepayment edits.

3. Third Party Benefit Recovery Module

   a. Identify third party resources.

   b. Establish collection and recovery procedures.

   c. Establish accounting and reporting procedures.

   d. Establish audit and control procedures.

4. Third Party Management and Administrative Reporting Module

Internal reporting capabilities (either manual and/or automated) must exist which provide adequate accounting and financial control. The reporting must provide information to management for planning and control of the TP efforts. States must possess the capabilities to meet the Federal reporting requirements in the TP area and for the Health Care Financing Administration's "Quarterly Statement of Medical Assistance Expenditure" (HCFA-64-9a).

E. Third Party Resource Data Base

1. Introduction

Federal regulatory requirements provide that State agencies administering the title XIX Medicaid program provide reasonable measures to determine the legal liability of third parties to pay for services under the State plan. The main function of the TP resource data base is to be the repository for the recording and maintenance of information relating to the resources available to the Medicaid recipient.

a. Objectives

The objective of the TP resource data base module is to define minimum third party data elements. These data elements are for use in supporting the Medicaid program administration processes of cost avoidance (diverted funds) or benefit recovery, or a combination of both.

b. Concept

The third party resource data base module is a general design with the capability of utilizing information from either one file or a series of interlinkable data sources, automated and/or manual, to perform the functions specified in Section C.

c. General Description

The TP resource data base performs the following functions:

(1) Initially establishes a data base which contains third party data of the Medicaid recipient.

(2) Receives recipient third party health insurance information.

(3) Receives recipient third party casualty insurance information.

(4) Processes and edits data pertaining to recipient third party information.

(5) Updates the third party resource data base with all valid transactions.

(6) Identifies incomplete or erroneous data through edits.

(7) Corrects incomplete or erroneous data.

(8) Controls the manual and data processing functions to ensure all transactions are accounted for and properly processed.

d. Information Flow

There are various sources from which TP resource information is available. The most significant of these resources is the individual Medicaid recipient, family member, or other legal representative. The case/social worker is the most logical individual to gather the information relating to the health care resources available to the recipient. The information is to be obtained at the initial application for eligibility determination, whenever a change in existing information occurs, and is to be verified at eligibility redetermination. The data is forwarded to the TP unit which has the responsibility for recording and maintaining the resource data base. There is a wide range of third party entity resources available to the Medicaid recipient. The data elements and information flow defined herein are considered to be of the absolute minimum, necessary to support cost avoidance and benefit recovery administrative processes.

(1) Health insurance coverage minimum data elements to be part of the resource data base are:

(a) Recipient Name

(b) Social Security Number

(c) Recipient Identification Number

(d) Name of Policyholder

(e) Number of Health Insurance Policy/Certificate

(f) Insurance Policy Period

(g) Type of Insurance

(h) Release of Medical Information Authorization

(2) Casualty insurance coverage minimum data elements to be part of the TP resource data base are:

(a) Recipient Identification Number

(b) Recipient Name

(c) Type of Liability/Casualty Insurance

(d) Date of Accident/Injury/Illness

(3) Minimum data elements on claim information necessary for benefit recovery actions are:

(a) Claim Number/Transaction Control

(b) Provider Number

(c) Procedure Code

(d) Begin Date of Service

(e) End Date of Service

(f) Place of Service

(g) Procedure Charge

(h) Amount of Claim

(i) Payment Date

(j) Date Claim Received

(k) Amount of Settlement by Third Party

(l) Settlement Status Indicator

(4) Options exist for States to enter into billing agreements with insurance companies. These agreements will specify the type of information, time frames, accumulation of claims amounts, and reconciliation of outstanding claims billings.

2. Outputs

The TP recipient resource data base produces the following major outputs:

a. Third Party Resource Data Base

The data base can either be an extension of the recipient-eligibility data base or a separate data base of the known third party resources available to Medicaid recipients. The elements for the resource data base are defined in Section E.1.d of the information flow.

b. Third Party Resource Data Base Error Processing

This is a process of all TP resource transactions that were not acted upon because the transaction contained errors. This error process is used by the third party unit to investigate the error and process correction.

The report as a minimum contains the following items:

(1) Date of Report

(2) Transaction Data Elements

(3) Error Explanation

c. Summary Third Party Resource Data Base Control Process

This process provides for an audit trail of all purged data, adds, changes, and deletes to the TP resource data base to assure all transactions entered have been acted upon. Summary totals for the number of transactions entered in the data base will also be shown. As a minimum, this process is to contain the following items:

- Report Date
- Summary Totals
- Number of Recipients in Data Base From Prior Report
- Number of Recipients Added to the Data Base
- Number of Changes to the Data Base
- Number of Delete Actions to the Data Base
- Current Number of Recipients in Data Base
- Summary of Records Purged

3. Inputs

The TP resource data base inputs are:

- Third Party Resource Data Base
- The Medicaid Eligibility Master File
- The Medicaid Claim Transaction File

4. Program Performance Controls

See Third Party Resource Data Base, paragraph H 2f(1) this section.

F. **Third Party Cost Avoidance Module**

1. Module Introduction

The TP cost avoidance module is established to aid in the reduction of Medicaid expenditures through the cost avoidance process. This process is dependent upon the existence of current and accurate information on health insurance available to the eligible Medicaid recipient. The purpose of the cost avoidance process is to inform the providers of medical services of the known available health insurance of eligible Medicaid recipients. The provider can bill the third party resource directly and thereby reduce the cost to the Medicaid program both in service and administration.

a. Objectives

The TP cost avoidance module has as its objectives:

(1) The defining of methods to provide recipient health insurance information to Medicaid service providers.

(2) The rejection of claims prior to payment when a provider has not first sought reimbursement from the third party health insurance resources available to the recipient.

(3) The assurance that when third party health insurance is sought by the provider, valid claims will not be rejected or unduly delayed in the Medicaid reimbursement process.

(4) Support the necessary management and reporting requirements.

b. General Description

There are two generalized elements in the TP cost avoidance module. These elements can best be described as the dissemination of information and claims processing controls relating to TP involvement.

The first element, the dissemination of information, relates to the utilization of Medicaid recipient third party resource data. The TP resource data base contains the data relating to available health insurance resources of the Medicaid recipient. In order for providers to pursue the available health insurance resource prior to submission of a Medicaid claim, they must have knowledge that the health insurance resource exists. There are several methods by which the provider can be notified of the fact that a Medicaid recipient has health insurance resources available other than Medicaid.

The recommended approach is to annotate the Medicaid eligibility card or other medium used to identify the eligible recipient with an indicator that the recipient is believed to have active health insurance which the provider must pursue prior to billing Medicaid.

The second element, claims processing controls, defines generalized criteria which address claims review and control in the cost avoidance process. All Medicaid claims are subjected to screening prior to payment to determine if other resources exist. The claim is compared to the recipient eligibility record which indicates the existence of known TP. Claims with no known TP involvement are subjected to further screening defined in the benefit recovery module to determine the potential casualty involvement and if there is a possibility for recovery actions.

c. Information Flow

The TP cost avoidance module provides for the dissemination of recipient health insurance information to Medicaid service providers and the possible return of Medicaid claims in a cost avoidance process.

(1) Dissemination of Information

The cost avoidance module provides for the furnishing of health care insurance information available to the recipient.

If a separate TP resource data base is developed and maintained, the TP resource data base is matched to the client eligibility subsystem to determine the accuracy of the TP indicator. If a match occurs, the TP indicator is set. Procedures should be in place to ensure proper timing.

The indicator then is used as an identifier on the recipient eligibility card or other medium issued to identify the eligible Medicaid recipient.

The provider of medical services uses the indicator in the interview process of the Medicaid recipient to obtain the health insurance data for billing purposes.

(2) Cost Avoidance of Medicaid Claims

The Medicaid claim is validated against the eligibility subset to determine the eligibility status of the recipient. The determination is made as to the existence of third party resources available to the recipient. If no TP is known to exist, the claim is passed to the benefit recovery module to determine if casualty liability exists. Should the eligibility record indicate the existence of third party resources, the claim is subjected to further testing.

If the provider has collected an amount from a third party resource, the amount collected is determined to be "cost avoided" (diverted) and the claims are computed to determine the liability of the Medicaid program and the residue paid to the provider. These claims can be reviewed on a pre and/or postpayment basis to determine if the appropriateness of the amount cited as being cost avoided (diverted) is valid. In addition, claims having evidence that the provider has been denied reimbursement by a third party resource can be screened either in a pre or postpayment mode to assure that the reason for denial is valid. If a postpayment review method is utilized, there is a potential for benefit recovery actions, and the claim must be controlled until the liability determination is finalized.

Should the claim amount be less than the cost of recovery, the claim is paid. The amount of claims returned and the amount shown on claims as collected by providers are maintained for reporting requirements.

2. Module Outputs

The cost avoidance module outputs are:

a. Detailed list of claims returned to providers. The returned claims should be shown on the remittance statement as provided for by CP-O-12, Volume II, MMIS GSD. The information therein should include:

- Provider Number
- Recipient Name
- Recipient Identification Number
- Type of Third Party Resource
- Claim Number/Transaction Control
- Procedure Code

- Dates of Service
- Amount of Claim
- Allowable Procedure Payment

Totals should be shown of amounts rejected by provider and a summary total of all rejected claims with third party involvement. This report is used to respond to the cost avoidance process.

b. A report which defines the collections of third party resources as cited on the claim. The report should contain the following mnimum elements:

- Provider Number
- Claim Number/Transaction Control
- Third Party Payment Amount

This report is used to determine the amount of third party resource collections made by providers during a Medicaid claims processing cycle.

c. Produce an exception listing which identifies Medicaid claims which cite amounts of provider (third party payment amount) collections that are exceptionally low in proportion to the amount billed by the provider. In developing this listing the single State agency is to establish a percentage or an amount that is an acceptable minimum (e.g., the collection amount is less than 40 percent of the amount billed, or the net paid amount is less than the determined cost effective to pursue). This listing should contain the following minimum elements:

- Claim Number
- Provider Number
- Amount of Claim
- Third Party Payment Amount (amount collected by the provider)
- Payment Amount (net amount paid by Medicaid)
- Difference (computed percentage or amount)

The followup listing is used by the TP unit to determine the accuracy and validity of the collection amount cited on the individual claim.

3. Module Inputs

The TP cost avoidance module uses the following inputs:

- The Third Party Resource Data Base
- The Medicaid Eligibility Master File
- The Medicaid Claims Transaction File

4. Program Performance Controls

See Cost Avoidance System Method, paragraph H 2f(2) or Combination System Method, paragraph H 2f(4) depending on method used.

G. Third Party Liability Benefit Recovery Module

1. Module Introduction

The Third Party Liability Benefit Recovery function as defined under title XIX is to recover resources which are due to the title XIX program. Benefit recovery activities apply when it is known that TP exists or has the potential to exist. Sources of recovery are commonly health or casualty insurances, Workmen's Compensation, and other resources determined or determined to have the potential to be legally or contractually responsible for part or full payment for the medical services rendered to eligible Medicaid recipients. The high potential areas of collections include the medical and hospitalization insurances. Other areas with high probabilities of collection are Auto Insurances, Casualty and Fire Insurances, Workmen's Compensation, Tort actions in which Medicaid recipients are involved, and the medical support obligations as provided for by title IV subpart D of the Social Security Act.

The purpose of TP benefit recovery function is to describe the environment, organization, development, procedures necessary in producing a workable system in the title XIX program. The benefit recovery system is to serve as a guide to be used in the identification of those claims with a potential for recovery where possibilities of third party payors exist and for which cost avoidance procedures may not be used.

The purpose of this module is to identify the kinds of commitments, constraints, alternatives, and factors that must be considered for the development of an effective benefit recovery activity. This is to insure the return of Federal and State dollars paid out for medical services where other resources exist.

a. Objectives

The TP benefit recovery module is designed to expedite the recovery of Medicaid expenditures from third party resources, either known or unknown at the time the medical service claim is paid. The objectives of the benefit recovery module are:

(1) Establish guidelines for reporting all benefit recovery activities at State and Federal levels.

(2) Ascertain and set forth all legal and regulatory requirements as set forth by the State and Federal Governments.

(3) Establish payment procedures to Medicaid recipients of overages (see glossary) as required by section 1912(b) of the Social Security Act.

(4) Establish a procedure for the identification, recording, and updating of third party resources available to each recipient.

(5) Establish a billing and accounting procedure for potential and recovered TP funds relating to Medicaid expenditures.

(6) Establish social worker/caseworker as interface between recipient and Medicaid for the gathering of TP information.

(7) Provide for automatic edits and screening of Medicaid claims for the purpose of identifying those claims having potential TP.

b. General Description

The benefit recovery module of the TP subsystem is designed to determine the identity or potential existence of a client recipient's third party resources. Each claim will be edited to determine what potential resources exist and/or whether there exists a valid third party resource.

All claims that pass through the benefit recovery module will be paid without regard to the existence of resources. Once the claim has been determined to have the potential for reimbursement from a third party resource, the third party will then be identified and billed for services. Claims billed to third parties will have accountability established for subsequent reconciliation.

c. Information Flow

The third party benefit recovery module provides for the determination and/or identification of recipient insurance information (i.e., health, casualty, tort, etc.) of all claims not cost avoided (diverted).

(1) Dissemination of Information

The benefit recovery module provides for the identification of all resources available to recipient for which Medicaid made payments and for the reasonable recovery of those payments. Collections cited by providers are to be accounted for as amounts cost avoided (diverted). These collection amounts are required for the HCFA 64-9a form, Quarterly Report of Expenditures for Medical Assistance.

The claim will be paid by Medicaid. The reimbursement amount of the claim(s) is edited to ascertain if the amount is less than the cost of recovery. If so, then no further action is necessary to seek recovery. When the amount of the claim exceeds the cost of recovery amount, a determination will be made if any health insurance or other resources exist. If health insurance is determined to exist, the TP data base will be updated with insurance information and payment will be pursued by the benefit recovery process, or else the claim will be tested for casualty liability involvement and edited for both health and casualty.

(2) Benefit Recovery of Medicaid Claims

The provider of Medicaid services will be paid prior to the validation of any third party resource information. The Medicaid claims are reviewed for possible existence of TP resources. The Medicaid

provider is required to ascertain and annotate Medicaid claims with third party information. Should the third party information be other than health insurance it will be added to the TP data base.

Claims with identified health insurance should be verified for validity; if the information does not exist in the third party resource data base it will be added. The benefit recovery section will bill claims to the known entity (Health, Casualty, Workmen's Compensation, etc.) for full or partial reimbursement.

Reconciliation of third party collection is accomplished through accounting procedures in the benefit recovery process.

2. Module Outputs

The benefit recovery module outputs are:

a. The following list of data elements will be necessary for design and development of TP claims returned to provider, TP Accident, TP Trauma Related Diagnosis and Procedures, TP Death, TP Billing, TP Collection and Reconciliation lists.

- Report Identification
- Program Identification
- Provider Identification Number
- Recipient Name
- Claim Number/Transaction Control
- Provider Number

- Procedure Code
- Dates of Service
- Date of Death
- Amount of Claim
- Amount Claim(s) Returned Identified TP
- Third Party Payment Amount
- Amount of Settlement by a Third Party

b. The above lists should:

(1) Identify recipients whose claim form did not indicate TP, however, the diagnoses and/or procedures have characteristics which indicate a need for investigation of possible third party involvement.

(2) Identify recipients whose claims indicate third party payments, but whose eligibility records indicate no third party resources.

(3) Identify Medicare coverage from the claim but not indicated on the eligibility record.

(4) Identify recipients for whom claims have been received indicating recipient's death, but whose eligibility record indicates they are still eligible for services (example: estates, etc.).

(5) Third party entity billing identifies the resource to be billed, billing item (Medicaid claim), health or other insurance policy data required and summary totals.

(6) Reconcile third party billings to collections and paid items not satisfied by the collection. This listing should also identify coverages which may ultimately be due to the recipient.

(7) Identify claims for followup that have known or potential third party involvement not pursued for recovery.

3. Module Inputs

The TP benefit recovery module uses the following inputs:

- The Medicaid Eligibility Master File
- The Medicaid Claims Transaction File
- The Third Party Resource Data Base

4. Program Performance Controls

See Benefit Recovery System Method, paragraph H 2f(3) or Combination System Method, paragraph H 2f(4) depending on the method used.

H. Third Party Management Administrative Reporting Module

1. Module Introduction

The third party management administrative reporting module supports the capability to produce TP reports.

a. Objectives

The third party management administrative reporting module has the following objectives:

(1) Report periodically on the status of claims with third party involvement.

(2) Provide for the generation of reports associated with the management and operation of the TP unit.

(3) Provide for the generation of reports specified by the Federal Government.

b. General Description

The general description and objectives of the third party management administrative reporting module is to provide guidance in developing reporting standards. The standards include:

(1) Defining the minimal reporting requirements in support of the TP function.

(2) Defining the types of reports necessary to support the third party unit management functions.

(3) Defining the frequency of output listings and reports necessary to support the operational requirements of the TP unit. The production and frequency of Federal reports are defined by Federal regulations and the single State agency is responsible for assuring that the Federal reporting requirements are met.

c. Information Flow

The TP management administrative reporting module provides for the preparation of reports for utilization by the TP unit.

(1) Preparation of Report

The management reports data is extracted from the third party resource data base, master recipient eligibility file, and Medicaid claims transaction file. Data is then formulated to periodically produce products that respond directly to Federal and State reporting requirements.

(2) Dissemination of Information

The third party unit provides for the distribution of reports, verification of outputs, and dissemination of information reports to proper channels as denoted by requirements.

2. Module Outputs

The following report items are considered minimum and must be produced as an integral part of third party processes.

a. Third Party Data Base Reports

Identify all Medicaid eligibles with third party resources. Summary counts are to be provided to indicate the number of eligible recipients with third party resources, adds and deletes within the reporting period.

b. Third Party Cost Avoidance Summary Reports

(1) Identify the amount returned to the provider because of known TP involvement.

(2) A report which summarizes the collection of third party resources as cited on the claim. The report should contain the following minimum elements:

- The Amount Billed by the Providers
- The Amount Collected (third party payment amount) by the Providers from TP Resources
- Allowable Procedure Payment
- The Net Amount Paid from Medicaid Dollars
- The Percentage of Provider Collections Versus the Allowable Procedure Payment

This report is used by the TP unit to support in part the requirements of the HCFA 64.9a and provide insight into the participation of providers into the cost avoidance activity of the Medicaid program.

c. Benefit Recovery Summary Reports

(1) Identify the amounts which have been pursued for recovery as a result of TP billings.

(2) Identify the amounts received with third party collections made by providers.

(3) Identify the amounts collected as a result of third party billings.

(4) Identify the amounts with other miscellaneous collections.

(5) Identify the amounts outstanding for each billing cycle.

d. Recommended Reports

A cost analysis report which analyzes the cost of operation of a third party unit to the activities of cost avoidance and benefit recovery.

e. Federal Reports

Quarterly schedule of TP collections for the Medical Assistance Program, HCFA 64.9a. This report identifies the status of TP claims, accountability for Federal funds by resources and cost avoidance third party claims.

f. Program Performance Controls

Program performance controls are items produced by the system. These performance measures will vary, dependent upon the option of third party claims administration (cost avoidance, benefit recovery, or a combination). Third party resource determination is required regardless of the method used by the State. Performance measures for the MTPLD&BR subsystem are:

(1) Third Party Resource Data Base

Regardless of the option selected by the State for third party liability claims administration, a TP resource data base is required. The performance controls for the data base are:

- Capture and maintain third party resource data on eligible Medicaid recipients.
- Provide to the Medicaid eligibility and/or claims processing subsystem a third party indicator.
- Produce third party resource data base reports or listing as required.

(2) Cost Avoidance System Method

Performance controls for a cost avoidance (prepayment) system option are:

- Identification of eligible Medicaid recipients with available third party resources.
- Identification of Medicaid claims with known third party involvement.
- Identification of Medicaid claims with a potential for third party involvement.
- Identification and recording the amount of payment remaining due the provider (within the States payment schedule) after the amount of third party liability has been established.
- Identification of unpaid Medicaid claims returned to the provider when third party involvement is known to exist and the provider has not made an attempt to seek reimbursement from the third party entity.
- Identification of followup actions to resolve liability of Medicaid claims suspended from payment because of potential third party involvement (if turnaround document is used).
- Operational reports produced on a timely basis to support State information requirements.
- Federal reporting requirements relating to third party involvement in the Medicaid program.

(3) Benefit Recovery System Method

Performance controls for a benefit recovery (postpayment) option are:

- Identification of eligible Medicaid recipients with available third party resources.
- Identification of Medicaid claims with known third party involvement.
- Identification of Medicaid claims with potential third party involvements.

- Identification and recording the amount of payment remaining due a provider (within the States payment schedule) after the amount of third party liability has been established.

- Identification of paid Medicaid claims identified for reimbursement from third party entities.

- Identification of collections from third party entities.

- Identification of all Medicaid claims that do not exceed the cost of recovery.

- Identification and recording the payments of overages to recipients.

- Operational reports produced on a timely basis to support State information requirements.

- Federal reporting requirements relating to third party involvement in the Medicaid program.

(4) Combination System Method

Performance controls vary when a State selects to use a combination option (cost avoidance and postpayment recovery). Each control is measured on its own merit and then only if it applies to the system requirements of the State. The performance controls should when applicable include:

- Identification of eligible Medicaid recipients with available third party resources.

- Identification of Medicaid claims with known third party involvement.

- Identification of Medicaid claims with a potential for third party involvement.

- Identification of the amount of payment remaining due a provider (within the States payment schedule) after the amount of third party liability has been established.

- Identification of all Medicaid claims that do not exceed the cost of recovery.

- Identification of unpaid Medicaid claims returned to the provider when third party involvement is known to exist and the provider has not made an attempt to seek reimbursement from the third party entity.

- Identification of followup actions to resolve liability responsibility of Medicaid claims suspended from payment because of potential third party involvement.

- Identification of Medicaid claims payments when third party liability cannot currently be established or is not currently available to pay for the recipients medical expenses.

- Identification of followup actions to resolve liability of paid Medicaid claims when third party liability cannot be currently established or is not currently available to pay for the recipients medical expenses.

- Identification of paid Medicaid claims for reimbursement from third party entities.

- Identification of collections from third party entities.

- Identification of the payment of overages to recipients (the amount reimbursed by the third party that exceeds the cost of services to the Medicaid program).

- Operational reports produced on a timely basis to support State information requirements.

- Federal reporting requirements relating to third party involvement in the Medicaid program.

3. Module Inputs

The third party management administrative reporting module uses the following inputs:

- The Third Party Resource Data Base

- The Medicaid Eligibility Master File

- The Medicaid Claims Transaction File

SECTION I

GLOSSARY OF TERMS

The definitions provided herein apply to the third party liability determination and benefit recovery subsystem of the Medicaid Management Information System (MMIS). These definitions have been extracted from MMIS publications, State and local existing MMIS operational systems, and regulations relating to the title XIX program.

Assignment of Medical Support Obligation - AFDC Title IV-D - The legal authorization for the State to pursue medical care and/or care payments on behalf of deprived child(ren).

Assignment of Rights - Legal authorization to act on behalf of the beneficiary in the pursuit of third party resources.

Benefit Recovery - (postpayment recovery) - A single State agency procedure which provides for the payment of Medicaid claims and then seek reimbursement from available third party resources. The existence of a third party resource may be known to the single State agency at the time payment is made or may be determined after the payment is made.

Casualty Insurance - Medical benefits available to beneficiary due to accidental injury or illness through the negligence of another. Casualty resources include auto liability, worker's compensation, commercial, and homeowner's liability policies, etc.

Cost Avoidance - A single State agency procedure providing the State with the capabilities to (1) return Medicaid claims to the provider when it is known in advance that a Medicaid eligible recipient has available third party resources; (2) account for provider collections applied to claims which reduce medical assistance payments; and (3) ensure that Medicaid program dollars are expended as the payor of last resort.

Diverted Funds - Those amounts saved from claims that are denied or reduced in amount as a result of applying prepayment screens to all or a particular portion of the claims submitted by a specifically identified provider when considering application of TP determinations.

Estate - The assets and liabilities of a deceased person (recipient).

Health Insurance - Any private insurer that is or may be liable to pay all or part of the medical, surgical, and/or hospital costs under the health insurance contract, plan, or policy (whether issued to the beneficiary or to someone other than the beneficiary). The plan may be private, group, or governmental (includes Medicare).

Other Resources - Other resources are defined as non-Medicaid (title XIX) dollars available from other entities which should or have been applied for services rendered to beneficiaries who are eligible for participation in the Medicaid program under the State plan.

Overage - The excess or surplus of funds collected by State agencies from third party entities which exceeds the State Medicaid allowable charge.

Private Insurer - Defined as follows:

1. Any commercial insurance company offering health or casualty insurance to individuals or groups; or

2. Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis or treatment of an injury, disease, or disability; or

3. Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer/employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

Provider Collections - Amounts which have been collected from TP resources and applied to the claim(s) by the provider of medical services. This amount is used to reduce the liability of the medical assistance (MA) program.

Release of Medical Information Authorization - A statement by the recipient for the purposes of conforming to the Privacy Act. This statement to release medical information must be in file and signed by the beneficiary, the guardian of a beneficiary or provided for by legislation.

Third Party - Any individual, entity, or program that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of a Medicaid applicant or recipient.

Title IV-D Agency - The organizational unit in the State that has the responsibility for administering or supervising the administration of a State plan for child support enforcement under title IV-D of the Social Security Act.

Tort - A wrongful act or injury or damage for which a civil action can be brought.

J. Third Party Liability Data Element Definition

Definitions and explanation of data elements developed for the TP subsystem are contained in this section. No attempt was made to redefine those data elements contained in Part 11 of the State Medical Manual or Volume V of the MMIS-GSD. Consideration in the development of these data elements was given to other subsystems under development; i.e., Eligibility and Long Term Care.

DATA BASE DESCRIPTION

DATA BASE NAME	DATA BASE NO.
MEDICAID THIRD PARTY LIABILITY DETERMINATION AND BENEFIT RECOVERY	
SUBSYSTEM NAME	DATE

ELEMENT NUMBER	MMIS ELEMENT REFERENCE NO.	DATA ELEMENT NAME	MINIMAL	RECOMMENDED
	101	NUMBER RECIPIENT IDENTIFICATION	X	
	103	RECIPIENT, NAME,	X	
	104	RECIPIENT, ADDRESS,		X
1104		RECIPIENT MARITAL STATUS		X
1100	-	ASSIGNMENT OF RIGHTS		X
1101	-	RELEASE OF MEDICAL INFORMATION AUTHORIZATION	X	
	134	NUMBER, SOCIAL SECURITY APPLICANT/RECIPIENT	X	
	113	THIRD PARTY LIABILITY CODE	X	
	112	DATE OF DEATH	X	
	114	BUY IN STATUS MEDICARE	X	
1102	-	NUMBERS, HEALTH INSURANCE POLICY/CERTIFICATE	X	
1103	-	NAME/INDICATORS HEALTH INSURANCE CARRIERS	X	
1105	-	ADDRESS, INSURANCE COMPANIES		X
1106	-	INSURANCE POLICY PERIODS	X	
1107	-	POLICYHOLDER, NAME	X	
1108	-	POLICYHOLDER, RELATIONSHIP TO RECIPIENT		X
1109	-	ADDRESS OF POLICYHOLDER		X
1110	-	TYPE INSURANCE	X	
1111	-	RECIPIENT EMPLOYMENT STATUS		X
	300	CLAIM NUMBER/TRANSACTION CONTROL	X	
	322	PROCEDURE CHARGE	X	
	321	AMOUNT OF CLAIM	X	
	342	DATE CLAIM RECEIVED		X
1112	-	AMOUNT, ACCUMULATED THIRD PARTY CLAIMS		X
1113	-	DATE, THIRD PARTY RESOURCE BILLING	X	
1114	-	AMOUNT OF SETTLEMENT BY A THIRD PARTY	X	
1115	-	AMOUNT, OVERAGE DUE RECIPIENT		X
1116	-	SETTLEMENT STATUS INDICATOR	X	
	312	BEGIN DATE OF SERVICE	X	
	313	END DATE OF SERVICE	X	
	314	PLACE OF SERVICE	X	
	380	ALLOWABLE PROCEDURE PAYMENT	X	
	376	PAYMENT DATE	X	

MMIS THIRD PARTY LIABILITY SUBSYSTEM
GENERAL DESIGN DOCUMENTATION

DATA BASE DESCRIPTION

DATA BASE NAME	DATA BASE NO.
MEDICAID THIRD PARTY LIABILITY DETERMINATION AND BENEFIT RECOVERY	
SUBSYSTEM NAME	DATE

ELEMENT NUMBER	MMIS ELEMENT REFERENCE NO.	DATA ELEMENT NAME	MINIMAL	RECOMMENDED
	500	PROCEDURE CODE	X	
	510	PROCEDURE DESCRIPTION	X	
	201	PROVIDER NUMBER	X	
	202	PROVIDER NAME	X	
	349	PAYMENT AMOUNT (DUE PROVIDER CLAIM TRANSACTION)	X	
	329	THIRD PARTY PAYMENT AMOUNT	X	
	385	THIRD PARTY FOLLOW-UP FLAG	X	
	328	THIRD PARTY LIABILITY ACTION	X	
1117	-	AMOUNT, CLAIM(S) RETURNED IDENTIFIED TP	X	
1118	-	NAME OF ATTORNEY/ADJUSTER		X
1119	-	ADDRESS OF ATTORNEY/ADJUSTER		X
1120	-	TELEPHONE NUMBER OF ATTORNEY/ADJUSTER		X
1121	-	TYPE OF LIABILITY/CASUALTY INSURANCE	X	
1122	-	DATE OF ACCIDENT/INJURY/ILLNESS	X	
1123	-	PLACE OF ACCIDENT/INJURY/ILLNESS		X
1124	-	NAME OF LIABILITY/CASUALTY THIRD PARTY		X
1125	-	ADDRESS OF LIABILITY/CASUALTY THIRD PARTY		X
1126	-	NAME OF LIABILITY/CASUALTY INSURANCE COMPANY		X
1127	-	POLICY NUMBER, LIABILITY/CASUALTY THIRD PARTY INSURANCE COMPANY		X
1128	-	LIABLE THIRD PARTY INSURANCE COMPANY CLAIM NUMBER		X
1129	-	RECIPIENT EMPLOYER'S NAME/COMPANY OR CODE		X
1130	-	RECIPIENT EMPLOYER'S ADDRESS		X
1131	-	TYPE OF THIRD PARTY RESOURCE	X	

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
ASSIGNMENT OF RIGHTS	1100

DEFINITION

A STATEMENT SIGNED BY THE APPLICANT OR RECIPIENT ASSIGNING BENEFITS AVAILABLE FROM SOURCES OTHER THAN THE MEDICAID (TITLE XIX) PROGRAM.

REMARKS

IN STATES WHERE ASSIGNMENT OF BENEFITS IS A CONDITION OF ELIGIBILITY, OR THE STATE HAS BLANKET RIGHT OF ASSIGNMENT BY STATUE AN ADDITIONAL SIGNED STATEMENT IS NOT NECESSARY.

CODE EXPLANATION

CODE	MEANING
0	NO SIGNED STATEMENT REQUIRED
1	CONDITION OF ELIGIBILITY
2	SIGNED STATEMENT ON FILE

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
RELEASE OF MEDICAL INFORMATION AUTHORIZATION	1101

DEFINITION

AN INDICATOR CITING THAT THE ELIGIBLE RECIPIENT HAS SIGNED A STATEMENT AUTHORIZING THE RELEASE OF INFORMATION.

REMARKS

NOT REQUIRED IF THE AUTHORIZATION TO RELEASE MEDICAL INFORMATION IS PART OF THE ELIGIBILITY APPLICATION.

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
NUMBERS, HEALTH INSURANCE POLICY/CERTIFICATE	1102

DEFINITION

A NUMBER ASSIGNED TO INSURANCE CONTRACT.

REMARKS

THIS IDENTIFICATION IS PRESENT ON ALL POLICIES ISSUED. THE POLICY/CERTIFICATE NUMBER IS REQUIRED ON ALL CORRESPONDENCE WHEN SUBMITTING A CLAIM.

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
NAME/INDICATORS INSURANCE CARRIERS	1103

DEFINITION

AN INDICATOR WHICH DEFINES THE NAME OF THE LIABLE OR POTENTIALLY LIABLE ENTITY.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
RECIPIENT MARITAL STATUS	[illegible]

DEFINITION

INDICATES THE CURRENT MARITAL STATUS OF THE INDIVIDUAL.

REMARKS

CODE EXPLANATION

CODE	MEANING
1	MARRIED
2	NEVER MARRIED
3	DIVORCED
4	SEPARATED
5	WIDOWER
6	WIDOW

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
ADDRESS, HEALTH INSURANCE COMPANIES	1105

DEFINITION

THE ADDRESS OF THE LIABLE OR POTENTIALLY LIABLE HEALTH INSURANCE COMPANY.

NORMAL ADDRESS CONFIGURATION

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
INSURANCE POLICY PERIODS	1106

DEFINITION

BEGINNING AND ENDING DATES OF HEALTH INSURANCE COVERAGES IN FORCE.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
POLICYHOLDER, NAME	1107

DEFINITION

NAME OF PERSON OR ENTITY TO WHOM THE POLICY OR CERTIFICATE WAS ISSUED.

REMARKS

THIS DATA ELEMENT IS REQUIRED IF THE POLICYHOLDER IS OTHER THAN THE RECIPIENT.

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
POLICYHOLDER, RELATIONSHIP TO RECIPIENT	1108

DEFINITION

IDENTIFICATION OR POLICYHOLDER'S RELATIONSHIP TO ELIGIBLE RECIPIENT.

REMARKS

THIS DATA ELEMENT IS REQUIRED IF THE RECIPIENT NAME IS DIFFERENT THAN THE POLICYHOLDER'S.

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
ADDRESS OF POLICYHOLDER	1109

DEFINITION

PLACE OF RESIDENCE OF THE POLICYHOLDER.

REMARKS

THIS DATA ELEMENT IS REQUIRED IF ADDRESS IS DIFFERENT THAN THE RECIPIENT'S ADDRESS.

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
TYPE OF INSURANCE	1110

DEFINITION

DEFINES THE TYPE OF HEALTH INSURANCE RESOURCE THAT EXISTS FOR A RECIPIENT, E.G., MAJOR MEDICAL, DENTAL, VISION OR COMBINATIONS THEREOF.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
RECIPIENT EMPLOYMENT STATUS	1111

DEFINITION

AN INDICATOR WHICH IS USED TO RECORD THE EMPLOYMENT STATUS OF THE RECIPIENT.

REMARKS

THIS DATA ELEMENT IS USED IN DETERMINING IF THE THIRD PARTY RESOURCE EXISTS THROUGH EMPLOYER.

CODE EXPLANATION

CODE	MEANING
1	RECIPIENT UNEMPLOYED
2	RECIPIENT EMPLOYED

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
AMOUNT, ACCUMULATED THIRD PARTY CLAIMS	1112

DEFINITION

THE TOTAL AMOUNT OF CLAIMS ACCUMULATED FOR CASE.

REMARKS

1. FOR A NUMBER OF CLAIMS WHEN THE TOTAL AMOUNT OF ACCUMULATED CLAIMS REACHES A DOLLAR LEVEL, E.G., $50.00.
2. THE AGE OF THE EARLIEST CLAIM IS EQUAL TO 90 DAYS.
3. THE DATA ELEMENT IS USED WHEN A FORMAL WRITTEN AGREEMENT EXISTS BETWEEN A STATE AND A LIABLE THIRD PARTY ENTITY FOR BILLING THIS IS ACCOMPLISHED TO FACILITATE RECOVERY ACTIONS.

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
DATE, THIRD PARTY RESOURCE BILLING	1113

DEFINITION

THE DATE THE SINGLE STATE AGENCY SUBMITS A BILLING TO A HEALTH OR CASUALTY INSURANCE COMPANY OR TO ANOTHER THIRD PARTY ENTITY FOR REIMBURSEMENT.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
AMOUNT OF SETTLEMENT BY A THIRD PARTY	1114

DEFINITION

THE AMOUNT OF MONIES COLLECTED BY THE STATE AGENCY IN THE SETTLEMENT OF A CLAIM AGAINST A LIABLE THIRD PARTY.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
AMOUNT, OVERAGE DUE RECIPIENT	1115

DEFINITION

THE AMOUNT OF MONIES COMPUTED AS DUE A RECIPIENT BECAUSE THE LIABLE THIRD PARTY REIMBURSED THE SINGLE STATE AGENCY MORE THAN WAS PAID TO THE PROVIDER BY THE AGENCY.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
SETTLEMENT STATUS INDICATOR	1116

DEFINITION

AN INDICATOR WHICH DEFINES THE STATUS OF A THIRD PARTY LIABILITY CLAIM(S).

REMARKS

CODE EXPLANATION MAY BE EXPANDED TO FIT OPERATIONAL NEEDS.

CODE EXPLANATION

CODE	MEANING
1	CLOSED WITH MONIES COLLECTED IN FULL
2	CLOSED WITH NEGOTIATED SETTLEMENT
3	CLOSED WITHOUT DOLLAR RESTITUTION
4	PENDING SETTLEMENT

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
AMOUNT, CLAIM(S) RETURNED IDENTIFIED TP	1117

DEFINITION

THE SUBMITTED AMOUNT OF A CLAIM(S) RETURNED AS UNPAID BECAUSE OF KNOWN THIRD PARTY LIABILITY EXISTENCE.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
NAME OF ATTORNEY/ADJUSTER	1118

DEFINITION

THE NAME OF THE ATTORNEY/ADJUSTER REPRESENTING THE LIABLE THIRD PARTY.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
ADDRESS OF ATTORNEY/ADJUSTER	1119

DEFINITION

THE ADDRESS OF THE ATTORNEY/ADJUSTER REPRESENTING THE LIABLE THIRD PARTY.

REMARKS

CODE EXPLANATION	
CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
NUMBER, TELEPHONE OF ATTORNEY/ADJUSTER	1120

DEFINITION

THE TELEPHONE NUMBER OF THE ATTORNEY/ADJUSTER REPRESENTING THE LIABLE THIRD PARTY.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
TYPE OF LIABILITY/CASUALTY INSURANCE	1121

DEFINITION

LIABILITY/CASUALTY INSURANCE AVAILABLE DUE TO ACCIDENTAL INJURY OR ILLNESS RESULTING FROM THE NEGLIGENCE OF ANOTHER.

REMARKS

LIABILITY/CASUALTY RESOURCES INCLUDE AUTO INSURANCE, NO FAULT AUTO, WORKER'S COMPENSATION, HOMEOWNER'S, LANDLORD, TENANTS, PRODUCTS, MALPRACTICE LIABILITY, ETC.

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
DATE OF ACCIDENT/INJURY/ILLNESS	1122

DEFINITION

THE DATE ON WHICH THE ACCIDENT/INJURY/ILLNESS OF RECIPIENT OCCURRED.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
PLACE OF ACCIDENT/INJURY/ILLNESS	1123

DEFINITION

THE PLACE WHERE THE ACCIDENT, INJURY, OR ILLNESS OF RECIPIENT OCCURRED.

REMARKS

CODE EXPLANATION	
CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
NAME OF LIABILITY/CASUALTY LIABLE THIRD PARTY	1124

DEFINITION

NAME OF THE INDIVIDUAL, COMPANY, ETC. POTENTIALLY LIABLE FOR RECIPIENT'S MEDICAL SERVICES. INCLUDES NO FAULT INSURANCE.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
ADDRESS OF LIABILITY/CASUALTY LIABLE THIRD PARTY	1125

DEFINITION

NORMAL ADDRESS CONFIGURATION.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
NAME OF LIABILITY/CASUALTY INSURANCE COMPANY	1126

DEFINITION

THE NAME OF THE INSURANCE COMPANY WHICH INSURES THE LIABLE THIRD PARTY.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
POLICY NUMBER, LIABILITY/CASUALTY THIRD PARTY INSURANCE COMPANY	1127

DEFINITION

THE NUMBER OF THE CASUALTY INSURANCE POLICY OF THE LIABLE PARTY.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
LIABLE THIRD PARTY INSURANCE CLAIM NUMBER	1128

DEFINITION

THE CLAIM NUMBER ASSIGNED TO THE RECIPIENT'S CLAIM BY THE LIABLE THIRD PARTY'S INSURANCE COMPANY.

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
RECIPIENT EMPLOYER'S NAME/COMPANY OR CODE	1129

DEFINITION

NAME OF THE INDIVIDUAL OR COMPANY WHICH EMPLOYEES THE APPLICANT/RECIPIENT.

REMARKS

THIS DATA ELEMENT IS USED IN POTENTIAL WORKER'S COMPENSATION OR OTHER CASUALTY INSURANCE.

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

D A T A E L E M E N T D E F I N I T I O N

DATA ELEMENT NAME	DATA ELEMENT NO.
ADDRESS OF RECIPIENT'S EMPLOYER	1130

DEFINITION

REMARKS

CODE EXPLANATION

CODE	MEANING

MODEL TPL MANAGEMENT INFORMATION SYSTEM
GENERAL DESIGN DOCUMENTATION

DATA ELEMENT DEFINITION

DATA ELEMENT NAME	DATA ELEMENT NO.
TYPE OF THIRD PARTY RESOURCE	1131

DEFINITION

DEFINES THE TYPE OF THIRD PARTY RESOURCE AVAILABLE TO THE RECIPIENT

REMARKS

CODE EXPLANATION

CODE	MEANING
1.	HEALTH INSURANCE
2.	CASUAL INSURANCE
3.	OTHER

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